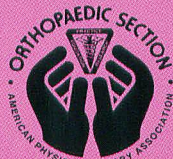


Orthopaedic Physical Therapy Practice



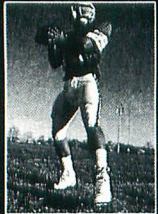
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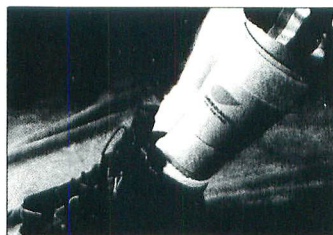
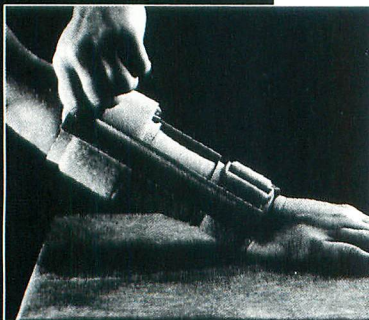
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Illustration in a 14th century manuscript illustrating placement of a bandage for jaw stabilization. (Ms. 1382, Biblioteca Casanatense, Rome)

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PASSION AND SLEEPLESS NIGHTS

Passion may be the source of many sleepless nights, but recently I experienced a night of insomnia fueled by an unusual type of emotion—passion for the profession.

On this particular night, I could not exorcise the demonic scenario that had played out in my clinic that morning. A young, angry patient, calling me a “quack”, grabbing her prescription from my hand and leaving my clinic in tears.

There were extenuating circumstances. I later found out that the young lady was a college student who had not slept in almost two days while preparing a final project. But that did not lessen my hurt nor allow me to stop agonizing over this incident. My ego was bruised, but that still didn't account for how hard all of this had hit me. It took some time, but I eventually realized that I was bothered by the fact that her conception of Physical Therapists might forever be distorted.

Later, after having a chance to sort it all out, I realized that after almost fifteen years I still cared enough about my patients and my profession to lose a little sleep over them.

APTA involvement is all about passion. Passion sustains our professional involvement. Take the time to recharge your professional batteries once in a while. Go to a District meeting.

Attend Combined Sections, Annual or State Conference. Consider being a delegate to the House.

I wish you all the same passion, and if it yields an occasional sleepless night—read the current issue of *Orthopaedic Practice*.



Jonathan M.
Cooperman
MS, PT

PRESIDENT'S MESSAGE

I actively began my term as President last month as a member ex officio to the Finance Committee. The formulation of the draft budget was an impressive process to watch. Meetings with financial and accounting advisors lead to development of fiscal recommendations to the Executive Committee. Not only was a draft budget of over 1 million dollars resolved but a suggested investment course was chartered. Programs were refined and new projects were added. Terms like Reserve Fund and Building Fund were discussed confidently as attainable goals. I attended my first Finance Committee six years ago and I was able to see that this committee has matured as its role has expanded. The strategic plan is no longer "tied to the budget" but rather it is the integral framework, designed by the Section Officers and Committee Chairs, on which this detailed budget is created. The budget process is completed at the Fall Executive Meeting in October with its review by the Committee Chairs and approval of the Executive Committee Members.

By the time you receive this issue of *Orthopaedic Physical Therapy Practice* the Executive Committee and Committee Chairs will have met in La Crosse. The anticipated agenda will begin with long term strategic planning, proceed through budget approval and culminate with committee reports, networking and action plans. A translation of this 90's business management jargon is—we are going to roll up our sleeves and directly run the Section for three days! Our hope is to steer the Section toward an effective course of professional actions to promote orthopaedic physical therapy and build on its apparent momentum. An update on actions will appear in the next issue of *Orthopaedic Physical Therapy Practice*.

The Task Forces on Reimbursement, Legislation, Organization Structure and Work Schedules are being formed. Bob Burles, P.T. is organizing the Reimbursement Committee and is coordinating the efforts with the Industrial Special Interest Group on a Workers Compensation Communication Network. Legislation is in need of a Chair but its subcommittees on Manipulation,

Referral for Profit, and Encroachment issues are forming. The members of the Task Force on organizational structure are being polled to create several structural plans to present to the Executive Committee. The Committee on Work Schedules will be meeting at the Fall Executive Meeting to propose revised activity calendars for the Section.

I am pleased to announce that many members responded to APTA requests for volunteers and over 200 chose to serve the Orthopaedic Section. I have sent letters requesting that these members designate specific areas of interest within the Section. If you receive one of these letters please respond quickly because we want to get you involved. If you have not volunteered to work with the Section yet — please do so! You can contact APTA Component Relations or call the Section office directly at 800/444-3982 to make your interest known. If you want to guide the profession of orthopaedic physical therapy in the years to come, to learn from talented peers from all over the country, to protect your practice from encroaching professions and to promote quality patient care become an ACTIVE section member.



Z. Annette Iglarsh,
P.T., Ph.D.
President

A letter was received at the Orthopaedic Section office from Geoffrey Maitland regarding his honorary life membership to APTA and the receptions that were held in his honor at Annual Conference in Denver this past June. His letter follows:

Anne and I have just arrived home from our long overseas lecturing trip and are now trying to catch up on our correspondence.

I would like to thank you, and the whole Orthopaedic Section for the Double Reception you put on for me at the Marriott City Center on June 13. It was very special and a great pleasure to know how you and your members thought of me and my contribution to our special area of Physical Therapy.

To have met so many of my old friends and to make so many new ones was a wonderful experience, one I shall never forget.

I realize that it was because of the Section's efforts that the APTA saw fit to make me an Honorary Life Member and I would like to thank you, one and all, for your support and enthusiasm. Could you please let your members know how touched Anne and I were, and are, for what you have done for us in the both the Reception and the Membership of APTA?

With our very special best wishes.

Sincerely,
Anne & Geoff

ORTHOPAEDIC SECTION MEMBERSHIP AS OF JULY 1992

PT ACTIVES	9,912
LIFE MEMBERS	119
PT ASSISTANTS	349
STUDENTS	541
TOTAL MEMBERSHIP	10,921

SAVING FOR COLLEGE? START EARLY, SAVE OFTEN

By Larry Boatman, an Investment Executive who provides investment advice to the Orthopaedic Section, APTA

Remember when young sales people would come to your door "working their way through college" selling magazine subscriptions? With the high costs of a college education today, selling magazines probably won't be enough.

Consider: the average cost of a single year at a public university today is \$7,000. A year at a private college is \$12,500. And the cost is rising nearly twice as fast as inflation. The cost of four years at a private college for a child born in 1990 is predicted to be almost \$150,000.

The path to successful college savings begins with an understanding of your future needs and your ability to withstand risk; a plan to meet those needs without taking undue risks; simple old-fashioned discipline; and the power of interest compounding.

Interest compounding is the magic that makes savings work. If you set aside \$1,000 at 8% interest, each year you get not only 8% of the original \$1,000, but 8% of the interest already earned. With compounding, your \$1,000 can double in seven or eight years. And if you set aside money on a regular basis, compounding really adds up. Time is your ally.

So where do you look for the best return for your kids? Here are three ideas that have proven successful and popular with college savers.

U.S. Savings Bonds have always been popular college investment vehicles. The Series EE Bonds purchased after January 1, 1990 have new federal tax exemptions for parents with joint incomes of \$60,000 or less which makes them especially appealing to parents. The federal tax exemption on the interest earned is an important feature — but you get it only if the proceeds are redeemed to pay college expenses. The bonds also are exempt from state taxes, regardless of the bond holder's income level. Safety is a primary feature of the U.S. Savings Bonds; the U.S. government guarantees principal and interest. One drawback is that U.S. Savings Bonds generally have lower interest rates than other investments so your savings will not grow as rapidly as with other investments.

Stocks are historically the best investment for growth over the long term, and parents with very young children should consider them. As college approaches, however, it may be wise to shift to safer, less volatile investments, like CD's, money market funds, or Treasury bills. Or you may shift from aggressive stocks to conservative issues offering solid dividend income. Stocks can be bought individually, or through mutual funds.

A Uniform Transfer to Minors Account (UTMA) is an account you create in your child's name. Under the law, you can gift \$20,000 (jointly) to your child yearly without paying a federal gift tax. UTMA's can invest in stocks, bonds, mutual funds, precious metals — just about anything. Such an account is especially beneficial after a child reaches 14, when returns in the account are taxed at the child's tax rate, not yours. Some parents who set these up invest in tax exempt vehicles until the child reaches age 14, and in taxable vehicles thereafter. But be warned — the money belongs to the account until the child reaches legal majority and then to him or her. Once deposited it's not legally yours.

How much per year must you set aside? If your child is a baby, between \$1,500 (public university) and \$4,000 (private). If your child is nine years old and you haven't yet started, figure on saving \$3,000 to \$7,000 per year. Ask your financial adviser to give you the specifics.

Parents don't have to raise every cent for college themselves, of course. There is about \$16 billion in loans, grants and scholarships available today, and that figure will probably rise along with tuition increases. You can borrow against your home. You can shop around for tuition "bargains". In addition, your child can take a job, perhaps even selling magazines door to door. But it is tremendously satisfying, and less expensive, to have made your own college savings plan succeed.

For more tips on saving for college, and a worksheet that will help you plan for college costs, Section members may contact Larry through the Orthopaedic Section office.

MEDICAL EXERCISE THERAPY: AN ADJUNCT TO ORTHOPAEDIC MANUAL THERAPY

By John Olson, M.A., P.T. and Bjorn Svendsen, DHSc., P.T.

INTRODUCTION

As orthopaedic physical therapists we are trained to assess and treat a number of different tissues. Embryological development and the differentiation of the mesodermal tissues gives rise to the majority of these musculoskeletal tissues, exclusive of nervous tissue.¹ It is this differentiation in the embryo that allows for the development of specialized tissue such as connective tissue, bone, muscle, tendon, and cartilage. These tissues vary in biomechanical properties and in form. However, the actual composition is quite similar. The intracellular and extracellular makeup of these tissues often has only subtle variations. Intracellular organelle composition is typically consistent from tissue to tissue with variability demonstrated primarily in response to the specific physiological demands of a tissue.¹ Extracellular makeup is also relatively consistent between tissues. The primary constituent of extracellular matrix in man is collagen, which makes up approximately 30% of the total protein content in man.² The collagen percentage of tissue dry weight has been found to be 75%, 75%, 50%, and 20-50% for tendon, ligament, cartilage, and disc, respectively.^{3,4,5,6,7,10}

The tissues of the musculoskeletal system are similar in that their metabolic demands are met by aerobic and anaerobic energy production. The levels of metabolic demand varies between tissues with contractile tissue having a high metabolic activity and articular cartilage/disc tissue having a relatively low metabolic activity.^{3,8,9,10} All of these tissues have also demonstrated different levels of activity with respect to a normal homeostatic state versus a remodeling or repair state.^{11,12,13,14,15} In light of the above it is evident that all tissues are metabolically active as opposed to being considered inert. As such, there is a baseline level of metabolic activity which allows tissue integrity to be maintained, and capacity for increased metabolic activity to respond to training or stress via remodeling and repair.

SPECIFIC ADAPTATION TO IMPOSED DEMAND

Wolff's law describes the adaptability

of osseous tissue to imposed demand. Wolff's Law states that trabecular bone formation will be laid down in the lines of stress placed on bone. A generalization of Wolff's Law to include the remodeling of soft tissue to imposed demand is typically met with conceptual acceptance.¹⁶ Wolff's Law suggests that there is an "appropriate" level of imposed demand, or "loading" of tissue. In the case of osseous tissue, if this loading is below a normal baseline level of stress, osteoclastic activity takes place. Similarly, if this loading is greater than the physiological properties of bone, traumatic breakdown or fractures take place. The literature not only represents this phenomena for bone tissue but also with soft tissue. Studies have shown that if stress on a tissue is decreased, tissue weakening and breakdown takes place.^{18,20,21,22} If stress is greater than the physiological limits of the tissue, trauma and/or injury occurs.^{16,17,18,19} Therefore, the generalization of Wolff's Law, suggests that there is a window of appropriate stimulus for soft tissues to maintain or increase their physical properties via remodeling. The research demonstrates that this concept is inclusive of ligamentous, tendinous, cartilaginous, and discal tissues.^{11,16,20,23}

As physical therapists we have evaluated and assessed tissues that have been exposed to either end of the "continuum of loading", with subsequent tissue failure being the end result. As a result we will prescribe physical therapy procedures to address the tissue involved. Often we look to provide intervention to alter tissue properties such as aerobic capacity/circulation, tensile strength or resistance to stretch, insertion strength, and tissue elasticity. Because we know that non-contractile tissue is metabolically active and reacts to the extremes on the continuum of imposed demand similar to bone and muscle tissue, it can be suggested that there is also an "appropriate" level of imposed demand for noncontractile tissue. Amdio (1992) has provided a theoretical schema of imposed loading to help illustrate the generalization of Wolff's Law to soft tissue (Figure 1).²⁴ All of the musculoskeletal soft tissues subsequently have the potential to respond to appropriate stimulus via

both remodeling and repair.

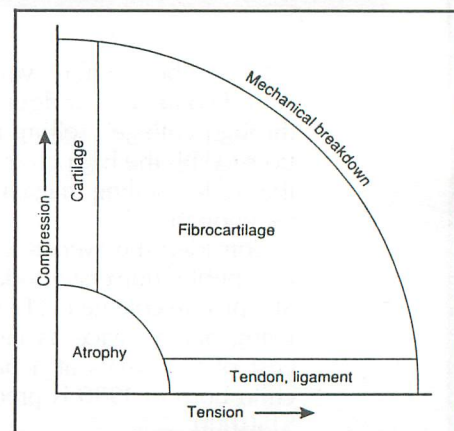


FIG. 1 Theoretical schema for Wolff's Law of soft tissue.

Imposing a level of appropriate stimulus to the various musculoskeletal tissues incorporates some variability. The literature has provided some evidence for what level of stimulus is necessary to create an environment optimal for repair and remodeling of tissue. In part, the repair and remodeling of tissue is a result of increased mitochondrial density, circulation and capillarization, increased aerobic enzyme capacity, and muscle/collagen fiber adaptation and realignment.^{2,12,27}

Muscular endurance and aerobic capacity has been found to change given exposure to a minimum of 20 minutes of submaximal exercise at a frequency of three times per week.²⁵ Muscular strength changes have been documented in response to a repetition based exposure. Experimental studies have found strength improvements for isometric, isotonic, and isokinetic strengthening with exposure to 3-5 sets of 6-12 repetitions at a percentage of the 1 repetition maximum (RM).²⁶

Tendon and ligamentous tissue have also been found to have a range of optimal exposure to loading stimulus. Experimental studies have found tendon healing to be initiated as early as 2-3 days after surgical trauma and remodeling of collagen fibrils as early as 3-9 days.¹² The literature suggests that optimal stimulus for tendon and ligament repair/remodeling requires exposure to hundreds of controlled repe-

tions.^{12,28} A minimum of 300 cycles/day of continuous passive motion provided an increase in tendon tensile strength and exposure to repetitions in the range of 1000-3000 repetitions of controlled exercise for increases in ligamentous strength and subsequent remodeling response.^{23,28,29}

Articular cartilage and intervertebral disc (IVD) are considered to be avascular and for the most part anaerobic. Both of these tissues however have been found to have a metabolism and remodeling response to training. Articular cartilage full thickness defects responded, in experimental studies, to exposure of 8 hours of continuous passive motion with remodeling of the articular cartilage.¹¹ The IVD subjected to a training stimulus of 40 minutes, 4 times per week, for 4 weeks responded with a 15% increase in the oxygen tension and a 40% decrease in the acidity.²⁰ This finding suggests that the IVD can respond to a training stimulus and has some potential for aerobic metabolism. Additional studies exposing the IVD to immobilization and subsequent retraining also suggest a training response of the IVD.⁹ Holm (1983) hypothesizes that ischemia of the disc brought on by immobilization/sedentary lifestyle and smoking may cause the initial and subsequent degeneration of the annulus and nucleus pulposus.^{9,20}

MEDICAL EXERCISE THERAPY

The origins of Medical Exercise Therapy (MET) is in a large part credited to the work of Oddvar Holten, a Norwegian trained manual therapist. As a manual therapist Oddvar Holten was dissatisfied with the success rate of pure "manual therapy treatments" which included passive low velocity as well as high velocity techniques. Holten noted that many patients experienced a return of the symptoms presented by the patient in many cases. During repeated treatments, some patients had a shorter and shorter time of benefit from the procedures applied. Consequently, he started developing exercises for patients to begin self mobilization and self stabilization regimens in his clinic. Medical Exercise Therapy became an accepted treatment approach by physical therapists in the Norwegian health care delivery system. Initial presentation and introduction to the United States by Holten and Svendsen took place in 1982.

Medical Exercise Therapy incorporates established exercise physiology principles to specific musculoskeletal tissues. MET is more an application of concepts and principles rather than a specific activity or procedure. Of primary importance to the application and utilization of MET is

the physical therapist's differential assessment of the "weak link of the chain." If the "weak link" is determined to be ligamentous then the application of optimal stimulus to increase the strength of the ligament is necessary. If the treatment is directed at contractile tissue, then a traditional approach of increasing muscular endurance and strength is applied. Not only does the exercise stimulus need to be accurately prescribed but it needs to be applied so as to not be limited by increased symptomatology, or muscular fatigue (if contractile tissue is not the focus of the exercise).

Medical Exercise Therapy requires an accurate prescription and application of the exercise stimulus relative to the involved tissue. There are, however, several additional considerations in the application of MET. These considerations include: positioning, functional exposure to exercise stimulus, and gravity. Positioning a body part in a way that allows for an abnormal pre-tension to be placed on a tissue can be, and often is, counter productive in the application of MET. The application of MET also emphasizes the use of an uncompensated functional pattern of exercise stimulus. The exposure to this stimulus allows for tissue remodeling and repair to take place in response to the directions of functional stress. Pathomechanical compensations in movement patterns are commonly associated with patients who suffer from pain/dysfunction of the musculoskeletal system. In order for true functional patterns to be present compensatory movements need to be eliminated.

The effect of gravity on the body is also an important consideration in Medical Exercise Therapy. Body weight and/or limb weight has an inherent loading stimulus on the musculoskeletal tissues. If the body weight or limb weight loading is beyond the loading tolerance of the tissue or "weak link" compensatory mechanics and/or nociceptive feedback results.

Once a differential assessment has been completed in regard to determining "the weak link of the chain" further functional testing is necessary. The purpose of functional testing is similar to a muscle strength assessment via manual muscle testing or isokinetic testing. It is meant to assist in the assessment of tissue strength and integrity, or what is considered "loading tolerance." Functional testing can be accomplished in a number of different ways. Active motion of a body part both with and without gravity or with additional resistance can provide functional input with regard to the tissues ability to withstand loading. Similarly, weight bearing tolerance of the spine and lower extremity

can also provide input into the capacity of the tissue to tolerate loading. Functional testing can also be accomplished by assessing the amount of physical or manual assists needed to perform a task without symptoms or compensation. Once a tissues maximal tolerable load is established a specific exercise prescription can be generated. This exercise prescription is then made relative to the tissue, incorporating an appropriate loading stimulus, duration, frequency, repetitions of exercise, and rest durations.

Medical Exercise Therapy offers a unique approach to the treatment of weakened tissue. In many cases the tissue considered to be the "weak link" is exposed to body or limb weights that are in excess of that tissues tolerable limits, and certainly in excess of that tissues therapeutic loading. As such, mechanisms for displacement or unweighting of body/ limb weight are necessary. Pulley systems are effective at allowing for removal of limb weight yet allowing for functional movement to take place, especially in the upper extremity. Unweighting systems have been utilized in conjunction with treadmills and upper body ergometry units to assist in the displacing of body weight for cervical, thoracic, lumbar, and lower quarter tissue weaknesses. Figure 2 demonstrates the use of a pulley and harness system to achieve partial weight bearing during treadmill ambulation and upper body exercises. Another commonly utilized mode of assistance is that of aquatic therapy. This mode, however, demonstrates considerable limitations with regard to capacity to manipulate body or limb weight assistance.

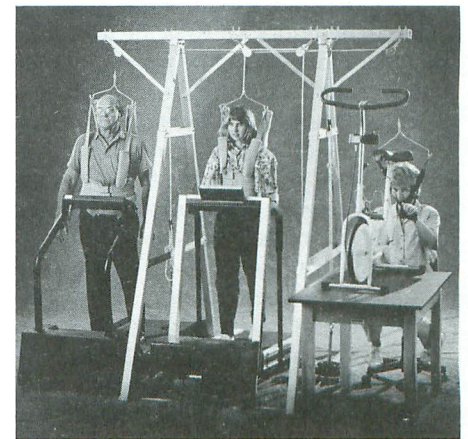


FIG. 2 This photo is courtesy of Vigor Equipment Inc.

Medical Exercise Therapy incorporates several phases of training to tissue. The initial phase is considered a restitutional phase. At this phase the primary goals are the elimination of symptoms, and max-

imizing oxygen delivery for tissue healing. The second phase is a protectional phase. The primary goal of this phase is to increase the tolerance and stamina of the tissue to functional stresses and ADL'S. The third phase is an advanced or upper border phase of training. The primary goal of this phase is to increase the tolerance and stamina of tissue to higher level athletic or work place stresses.

The application of MET and functional testing can be illustrated with several patient case studies. These scenarios do not depict the entire clinical picture and will assume that symptom referral from other structures has been ruled out.

CASE 1: Patient presents with supraspinatus tendonitis with partial disruption of collagen fibrils. Active motion of the glenohumeral joint finds reproduction of pain at 90 degrees of flexion and abduction. Capsular mobility and passive motion is normal. The "weak link" in this scenario is determined to be the tendon of the supraspinatus muscle. The maximal tolerable load of the tendon is considered to be less than limb weight. Exercise stimulus needs to expose the tendon to several hundred repetitions of a functional pattern of motion, pain free and without compensation by means of assisted arm elevation. Given a favorable resolution of symptoms over the course of several treatments a progression to higher level resistive training can ensue (pending tissue tolerance to loading).

CASE 2: Patient presentation of grade II lateral ankle sprain. Both active and passive motion are limited with a moderate increase in anterior drawer of the talocrural joint. Pain free weight bearing tolerance with the leg straight and the ankle in neutral is 100 pounds for a 150 pound patient. The "weak link" in this scenario is determined to be lateral ligamentous and capsular tissue. In this 150 pound patient the maximal tolerable load for weight bearing is 100 pounds. Given a 100 pound maximal load tolerance the optimal exposure for this tissue needs to be less than 100 pounds and incorporate a range of approximately 1000 repetitions to maximize the repair and remodeling of the ligament. Assisted treadmill ambulation is a mode of exercise in MET that offers the potential to stimulate this tissue via the removal or displacement of partial body weight in order to exercise, pain free and without substitution, in a functional pattern at a load less than the maximal tolerable load.

CASE 3: Patient presentation of bulging lumbar intervertebral disc. Patient demonstrates decreased tolerance to functional activities (i.e. lifting, bending) and to prolonged sitting postures beyond 10 minutes. Active motion of the lumbar spine is decreased for both flexion and extension with pain at end range. Non-weight bearing lumbar flexion and extension is normal and pain free. There is also increased segmental movement at the level of discal pathology. Functional testing via partial unilateral squats increased lumbar side shifting after 10 repetitions. This scenario presents with greater difficulty in the determination of the "weak link." Is the lack of active motion and increase side shifting with unilateral squatting more a result of disc pathomechanics, lack of neuromuscular control, or both? A conservative approach would be to address the disc tissue with MET initially. This would require functional stimulus (i.e. assisted treadmill ambulation) at a load less than the maximal tolerable load which is determined from the functional testing. This exposure again can be accomplished via assisted treadmill ambulation (pain free and without substitution) for durations of 40 minutes or greater.

CONCLUSION

Medical Exercise Therapy can add significantly to the quality of orthopedic rehabilitation and for some musculoskeletal dysfunctions and be an effective adjunct to manual therapy procedures. Although the literature provides support for the concepts integrated into medical exercise therapy there are some limitations in extrapolating the results of animal studies to human tissue. There also needs to be further research completed with respect to specific quantification of loading stimulus in the remodeling of the different musculoskeletal tissues.

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MEDICAL MALPRACTICE & PROFESSIONAL LIABILITY INSURANCE: THE NEED FOR PHYSICAL THERAPISTS TO BE INFORMED

By Sonya Robertson-Jones, M.S., P.T.

INTRODUCTION

The medical malpractice crisis for physicians appears to have peaked in 1985-1986, as evidenced by a reduction in the frequency and severity of malpractice claims since that time. There has been speculation among malpractice experts that physical therapists may not enjoy a similar trend. It is felt by some that claims against physical therapists will rise in direct proportion to their independence in the profession. (Ashcroft, 1990) If this is true, then physical therapists have a responsibility to understand the legal system and manage the risks that could lead to malpractice claims.

MEDICAL MALPRACTICE

Actions in malpractice fall under the area of tort law. A tort is a civil wrong for which a private right of action exists, whereas a criminal wrong is prosecuted by the state. That is, a tort is limited to personal injury by private parties, while a crime is defined by what the legislature has deemed to be wrongs against society as a whole. The goal of tort law is to impose enough liability to deter reckless acts, while not imposing so much liability that social relations are frozen.

A malpractice claim can be damaging in many respects: jeopardizing the respect of your patients, referral source, and community; producing excess anxiety; and incurring lost wages due to time away while defending your case. However, in order for a malpractice claim to be successfully prosecuted, the injured party (or plaintiff) must establish the four elements of the tort:

1. That the physical therapist owed the patient a duty of care;
2. That the physical therapist, breached that duty of care; and
3. That the patient was injured;
4. That the injury was a direct result of the physical therapist's breach of the duty of care.

The first element is rarely an issue of controversy. If a patient/physical therapist relationship exists, then it is a matter of fact that the patient is owed a duty of care.

The nature of the duty of care involves defining the standard of care which the

physical therapist's conduct will be measured. Thus the physical therapist must exhibit that same degree of skill, care, and judgment ordinarily exhibited and accepted by their peers. The American Physical Therapy Association (APTA) House of Delegates has adopted the "Code of Ethics" and "Standards of Practice." Some state boards have adopted APTA's "Guide for Professional Conduct," which interprets the "Code of Ethics," as their rules of professional conduct. Once adopted, the "Guide" becomes a legally based standard of practice and conduct for the physical therapy profession, by which the actions of the physical therapist will be judged.

For the third requirement, actual harm must result. Injuries can include the exacerbation of current symptoms or the appearance of new symptoms. Theoretical harm does not suffice. The last element, proving that the conduct by the physical therapist was the direct cause of the plaintiff's injury, is often the most difficult to establish.

To sustain an action in malpractice, *all four* of the above mentioned elements must be established. However, the proceedings will not be a one-sided presentation of the plaintiff's arguments.

AVAILABLE DEFENSES

The physical therapist has several defenses at her disposal. Whenever possible, the attorney for the physical therapist will bring forth testimony and evidence that contests the plaintiff's efforts to establish those four elements. (Harker, 1990)

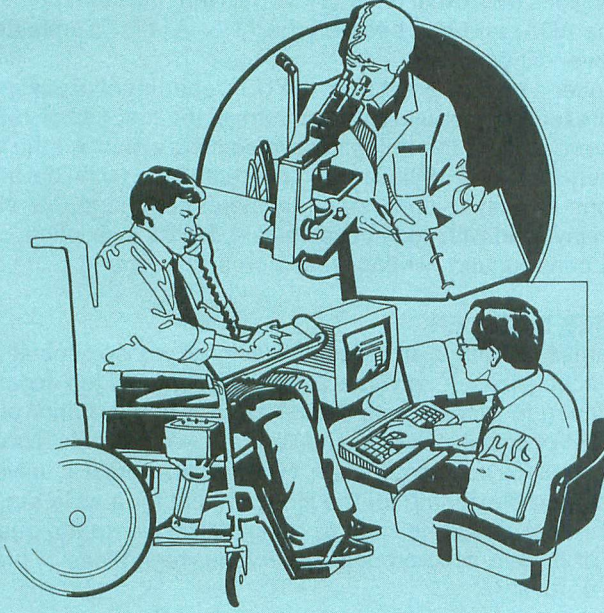
Beyond these basic challenges, there are additional defenses at the defendant's disposal. The actions of the physical therapist may be covered under a state malpractice statute, delineating the course of action the plaintiff must follow to have any chance of successfully pursuing the matter. Another defense can be found in statutes of limitations, where the state limits the time in which actions can be brought to recover from instances of harm. Typically, the applicable statute of limitations begins to run at the time of the patient's

discovery of their injury. In addition, a number of states have enacted statutes that set absolute time limits from the date of injury for initiating a claim. For example, in Oregon, the statute of limitations is two years after discovery with a five year absolute time limit.

Another significant defense is *contributory negligence*, in which the plaintiff's conduct is considered as well as that of the defendant. There are two ways of assessing the plaintiff's fault. In contributory negligence jurisdictions, the plaintiff will not prevail if she was in any way contributorily negligent in causing her injuries. The harshness of this "all or nothing" rule has resulted in the majority of states implementing a standard of *comparative negligence*.

With comparative negligence, the amount of damages is reduced in proportion to the plaintiff's comparative fault. In Oregon and many other states, it is possible for the plaintiff to prevail only if they are less than 49 or 50% at fault, depending on the state's set limit. In "pure" comparative negligence jurisdictions such as the State of Washington, a plaintiff can recover even if she is greater than 50% at fault. Thus, with "pure" comparative negligence, if a plaintiff is 75% at fault and the defendant 25%, and the total damages are \$10,000, the plaintiff can recover \$2500 from the defendant. (Harker, 1990)

Assumption of risk, whether express or implied, may also be used as a defense. Assumption of risk centers around informed consent. According to Scott (1990), none of the reported cases involving physical therapists concerned the issues of informed consent. However, this should be a concern for every clinician, for every physical therapist is legally responsible for obtaining a patient's informed consent before treatment. The physical therapist is required to explain the proposed treatment, risks, benefits, alternatives, and prognosis to the patient. The patient should feel adequately informed to make the decision to accept or reject the proposed treatment. Speculation exists over whether the objectives of informed consent can



ADA— Practical Applications and the Physical Therapist's Role

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**Tuesday, February 2 and
Wednesday, February 3, 1992
San Antonio, Texas**

SCHEDULE

Day 1—Tuesday February 2, 1993

- 8:30 Welcome, Introduction
- 8:45—10:15 "Valuing Differences"—Geri Jewell
Attitudes and the ADA
- 10:15—10:30 BREAK
- 10:30—12:00 "ADA Building Blocks" (Part 1)—Mark
Rothstein, Attorney at Law
A comprehensive look at the ADA and
a legal perspective
- 12:00— 1:15 LUNCH BREAK (on your own)
- 1:15— 2:45 "ADA Building Blocks" (Part 2)—Mark
Rothstein
- 2:45— 3:00 BREAK
- 3:00— 4:30 "Pre-work screening and the ADA—
Physical Therapy Issues and a Case
Study"—Helene Fearon, PT; Susan
Deason, Safety Director, Smiths Food
and Drug Centers
- 4:30— 5:00 Panel Discussion, Questions and
Answers

Day 2—Wednesday February 3, 1993

- 8:30—10:00 "Title III—Access Issues"—John P.S.
Salmen, AIA
- 10:00—10:15 BREAK
- 10:15—12:00 "Universal Product Design and Job
Accommodation"—James Mueller, In-
dustrial Designer
A multidisciplinary approach to work-
place accommodation
- 12:00— 1:15 LUNCH BREAK (on your own)
- 1:15— 2:45 "Employment Issues—Title I"—EEOC
representative James Stone
- 2:45— 3:00 BREAK
- 3:00— 5:00 "Practice Issues Panel & Case
Studies"—Dennis Hart, PhD, PT; Su-
san Isernhagen, PT; Kim Osborne, PT;
Barbara Thompson, OTR

SPEAKERS

GERI JEWELL

Geri Jewell known to millions as "Cousin Geri" from NBC's "The Facts of Life". She is the first person with a disability to become a regular performer on a sitcom. Geri is an exceptional actress, comedienne, lecturer and motivational speaker famous for her ability to bridge the worlds of humor and attitudinal change. Her performances challenge the listener to open doors to new and healthier ways of perceiving themselves, others and the world they live in.

Geri has spent the last ten years speaking to a wide range of groups from the White House to the corporate world to social service organizations to college campuses throughout the United States. Her message, a universal one, serves to empower, heal and bring laughter to the hearts of her audiences.

MARK A. ROTHSTEIN

Mark A. Rothstein is Law Foundation Professor of Law and Director of the Health Law and Policy Institute at the University of Houston. He received a B.A. from the University of Pittsburgh and a J.D. from Georgetown University. Professor Rothstein has concentrated his research on employment and occupational health law. He has written over 50 articles on these subjects as well as five books, including *Medical Screening* and *the Employee Health Cost Crisis* (BNA Books 1989).

Professor Rothstein has lectured widely on issues such as medical screening of workers, AIDS, reproductive hazards, drug abuse, genetic testing, the Americans with Disabilities Act, and OSHA. He also has served as a consultant or adviser to numerous governmental and other bodies, including the following: the Secretary of Energy, Office of Technology Assessment of the United States Congress, American Medical Association, American Hospital Association and Institute of Medicine of the National Academy of Sciences.

HELENE FEARON

Helene M. Fearon, PT is a graduate of Marquette University, Milwaukee, Wisconsin. She and her husband own a private practice located in Phoenix, Arizona. Helene's interest area is in orthopaedic physical therapy, specifically in the area of injury prevention education, evaluation and treatment of the injured worker.

She has been involved in the development of prevention programs, functional job descriptions and pre-work screens for various industries across the U.S.

SUSAN DEASON

Susan Deason is safety director for Smith's Food and Drug Centers, Inc. in the California region. She has been integral in the development and implementation of Smith's pre-work screen program. Susan previously held this position with Smith's in their Southwest region and has been responsible for training Smith's employees in the area of safety concerns.

JOHN P.S. SALMEN

John P.S. Salmen, AIA is a licensed architect who has specialized in the area of Barrier Free and Universal Design for over 17 years.

He is a nationally prominent expert in the technical aspects of the Americans with Disabilities Act and its Accessibility Guidelines (ADAAG). He was involved with the development of the ADA, and has been on the ANSI A117.1 Committee for over 10 years.

Under a special grant from the US Department of Justice, he presented over 85 ADA seminars in the first half of 1992 in every state of the union. These seminars outlined the legal requirements of the law and presented the technical provisions in easy-to-understand layman's language. He has been involved with code development, facility evaluation, design construction, writing, research and teaching.

JAMES MUELLER

James Mueller is an industrial designer whose consulting firm specializes in universal product design and job accommodation for people with disabilities. He is the author of a number of books including *The Workplace Workbook*, a book on workplace accommodation. His special interest is universal design (designing for the life span and for a wide range of abilities), which he sees as a logical answer to the question of how to accommodate everyone, regardless of their age or ability.

DENNIS HART

Dr. Hart is a Physical Therapist who has earned a doctorate in Industrial Engineering. His first 15 professional years in academic settings prepared him to make reliable measures of function in people with chronic pain syndromes. He now manages Assessment Centers Technology which is an independent company that provides industrial consulting services in ergonomic job task analyses and redesigns, employee educational programs, and consulting in the management of work related injuries. ACT also provides clinical services of Functional Capacity Evaluations and Work Hardening Programs in three offices between Arlington, VA and Baltimore, MD. The staff members of ACT pride themselves in their continuing research efforts in the reliability of their clinical measurements which assist professionals in workers' compensation in the management of work related injuries.

SUSAN J. ISERNHAGEN

Susan J. Isernhagen is a physical therapist recognized as an expert in work injury management. President of Isernhagen and Associates, she directs consultation and education activities. Program development consultation, education and training is done in the fields of functional capacities evaluation, pre work screening, ergonomics and development of occupational medicine programs.

Susan has presented educational seminars and workshops both nationally and internationally. Her comprehensive book *WORK INJURY: MANAGEMENT AND PREVENTION* was published by Aspen in 1988.

KIM OSBORNE

Kim Osborne, PT, president and owner, founded Therapy Services Associates to meet the rehabilitation needs of Lea County, New Mexico. She is a General Practitioner who provides orthopaedic and pediatric services. A member of the New Mexico Physical Therapists' Licensing Board from 1986-1992, she also acted as President of that organization from 1988-1992. She has held various offices at the state level for the American Physical Therapy Association, including secretary, council member, and chairman of the South Eastern District. She has also been part of several national committees.

Kim has lectured locally and nationally on the ADA and Risk Management. Having a quadriplegic physical therapist on her staff has given her first hand experience with the ADA.

BARBARA THOMPSON

Ms. Barbara Thompson, OTR, CVE, CWA is an experienced occupational therapist, certified vocational evaluator and work adjustment specialist. She received her bachelors of science degree in occupational therapy from the University of Southern California and has received advanced training in the field of Occupational and Industrial Ergonomics from nationally renowned experts. Ms. Thompson's expertise is in the evaluation and modification of work places, work tools and work methods to either prevent cumulative trauma disorders or accommodate individuals with disabilities in the workplace.

Ms. Thompson is a principal in WorkAble Solutions, etc., a San Diego consulting company which specializes in employer training and consultation in the areas of injury prevention, disability management and compliance with the Americans with Disabilities Act. She conducts training seminars nationally and holds adjunct faculty positions with the San Diego State University Rehabilitation Counselor Program and the University of California, San Diego Extension.

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ever be truly realized, and controversy exists over the true need for written informed consent to be obtained by physical therapists. (Scott, 1990) In practice, the patient's assumption of risk (on the basis of informed consent) would be one of the weaker defenses available to the physical therapist accused of malpractice.

OBTAINING CONSENT

The subject of informed consent is receiving more attention, with direct access and the trend toward blanket orders to "evaluate and treat." With this increase in autonomy comes an increase in legal responsibility, and the potential increase in malpractice exposure. Consequently, many physical therapists are implementing risk management procedures to minimize such exposure. Banja and Wolf (1986), revealed that the majority of physical therapists do not use any form at all for consent. A minority use a form that consisted of a single-statement authorization to the effect that "I consent to the physical therapist's treating me according to the directions of my physician." They point out that such a consent form is grossly deficient in legally protecting the physical therapist in two respects. First, it does not state the doctor's directions. Therefore, the form cannot be used in court to say the patient consented to the treatment, because the nature, risks, and benefits are not indicated. Second, even if the patient signed the form, she can accuse the physical therapist of administering a treatment that was either not directed or that was different from what was directed by their physician. Without adequate documentation, the physical therapist is vulnerable in her defense.

Banja and Wolf propose a way to reduce the risk of malpractice action alleging nondisclosure of risks from physical therapy. They recommend implementing a simple description-of-treatment form with a check list of standard treatment interventions and a risk check list. The physical therapist will clarify the specific treatment and alternatives in a brief, written statement. The author concluded that the advantages of such a form are:

1. minimal time for completion;
2. a reasonable degree of responsibility placed on the patient to avoid potential risk of harm during physical therapy assessment and treatment procedures;
3. easy updating of the forms if physical therapy treatment changes;
4. and, an opportunity for the patient

and family to better understand the proposed treatment. (Banja & Wolf, 1986)

Scott, however, does not recommend a blanket use of written consent forms by physical therapists. There are some procedures that, in his opinion warrant written consent, such as electromyography, procedures with a high risk of injury—such as cervical manipulation, and physical therapy considered to be unconventional treatment. The reasons he gives for obtaining written informed consent in such procedures are the following: the patient is less likely to be well-informed about the procedures, and the patient may need a written description-of-treatment form to make an informed judgement. According to Scott, such a descriptive form and signed consent may offer legal protection for the physical therapist. However, he cautions that this does not offer a blanket of legal immunity. Whenever such forms are appropriate, they should be carefully drafted and then reviewed by an attorney. For routine procedures, he feels written informed consent forms are neither required nor appropriate. The time, effort and expense of drafting them and obtaining legal review does not justify creating them. He supports this claim by noting that cases involving lack of consent are among the rarest in malpractice claims. He discourages the use of these forms for "defensive health care," as the courts will probably not allow such forms as evidence at trial. And finally, he contends that the practice of the patient reviewing check lists and signing forms prior to treatment will erode the close relationship between the patient and physical therapist, thus jeopardizing "the innate immunity to claims and lawsuits inherent in that relationship." (Scott, 1990) Good rapport between patient and physical therapist is thought by some to be the best prevention against claims. (Hortling, 1989; Scanlon, 1987)

Scott suggests that there are simpler ways to simultaneously achieve informed consent and protect oneself from liability. One way is to develop practice routines for obtaining the patient's consent, including checklists which can be documented and stored in the clinic's policies and procedures manual. The required points can be imparted orally. In time, if a clinician uses the same routine to impart the same information, then they can later testify with confidence that they followed such routines and their staff should be able to verify their testimony. Thus, under this oral disclosure method, the legal requirements for informed con-

sent are probably met. It should be noted that this approach assumes that clinicians are familiar with the policy and procedures manuals within their facilities.

The malpractice crisis inspired the APTA to appoint a task force to analyze the malpractice dilemma and prescribe remedies. The files of Maginnis and Associates, insurers who sponsored group liability programs for APTA members, were reviewed from 1981-1986. During this time, 1061 claims were handled against both employed and self-employed physical therapists. These claims mounted to over \$6 million in payments and related expenses, with approximately \$5.5 million of the losses recorded for the self-employed physical therapist. For employed physical therapists the average claim cost was \$1750; for the self-employed physical therapist, average cost was \$7200.

Using the Maginnis data, the task force studies the sources of claims. The following results were reported: 35% of claims were the result of burns; 25% from over-manipulation; 15% from patient falls; 15% from injuries to patients undergoing gait training; 5% from whirlpool mishaps; 5% from traction injuries. With the sources of litigation identified, the APTA was able to develop effective risk management programs. One task force spokesperson commented: the task is to warn physical therapists to be more careful: it all boils down to common sense. (Scanlon, 1987)

In a recent study by the Interstate Insurance Group, another insurer of physical therapists, it was revealed that 70% of liability claims occurred in a private physical therapy clinic or office. The remainder occurred in hospitals, nursing homes, private residences, health clubs and schools. The study attempted to ascertain the cause of loss. In the cases studied, the alleged injuries, were grouped as follows: 19% included fractures; 13% burns; 13% chemical and/or electrical burns; 8% reinjuries; 6% soft-tissue injuries; and 48% undefined. The study then examined the activity of the patient at the time of the alleged injury, with the following results: 26% were involved with heat/electrical treatment; 19% were exercising with and without equipment; 17% were caused by manipulation; 18% were due to slips and falls—10% were unsupervised, 8% supervised. To lay the groundwork for risk management, the study then examined the true cause of loss, that is, what the physical therapist failed to do that resulted in the alleged injury. The causes were

broken down as the failure to: perform a physical therapy diagnosis/to refer (10%); treat "properly" (46%); monitor patient (50%); maintain equipment (42%); follow doctor's orders (2%); and other (15%).

Equipped with such data, the obvious question is: How can claims be avoided? A summary of suggestions includes the following:

- Develop good rapport with patients;
- Never leave patients unattended;
- Thoroughly document every case;
- Clarify and document physician's orders;
- Do not be afraid to refer a patient to another specialist;
- Maintain clinical skills with continuing education courses;
- Discuss procedures with patients and obtain their consent;
- Work within the boundaries of your skill, training & experience;
- Check the operation and safety of all equipment;
- Use sound judgment and common sense.

As reported in 1989, a physical therapist stands a 1 in 10 chance during their professional career of being sued by a patient. (Horting, 1989). As a general rule, physical therapists are unaware of a malpractice claim until a lawsuit has been served. Because professional liability lawsuits can run into hundreds of thousands of dollars, knowing what your liability policy covers is the first step of any risk management program.

PROFESSIONAL LIABILITY PROGRAMS

Two types of professional liability are available. An "occurrence" policy covers claims made when the policy was in force, regardless of when the claim is reported. This type of coverage protects the physical therapist who changes jobs and policy holder, who changes professions, or who retires and is faced with a claim several years later. This type of *insurance tends to be more expensive*, as the insurer must estimate claims in the future and set up monetary reserves to cover costs. The second type of coverage is "claims-made," which only covers claims that occurred and reported while the policy is in force. Claims-made coverage typically starts out at a lower rate, and increases yearly with the physical therapists exposure. Most rates mature after 4-5 years.

Two options exist to fill any gap in coverage created by termination or changes in claim-made carriers. The first option is an extended reporting period

endorsement, which allows the insured to report a claim to the prior insurer after the policy has been terminated. The second option, offered as an inducement for customers to switch carriers, is the prior act endorsement. This allows physical therapists to purchase coverage through the new insurer against claims that have occurred but not yet reported. (Horting, 1991). Pricing for these two options can be prohibitively expensive. Occurrence coverage from the onset offers the potential to avoid excess rates and any gaps in coverage when changing carriers.

Without exception, it is recommended that physical therapists carry an individual professional liability policy in addition to what is offered by their employer. Exclusions, declarations, and definitions of the policy offered by an employer may create gaps in their coverage that they are unaware of until a claim is filed. In addition, as the physical therapy profession continues to enjoy its growing autonomy, physical therapists must continue to develop their expertise in managing not only the patients' needs but also liability risks as well.

REFERENCES

- Ashcroft, C.E. (1990). Introduction. *Risk Management Resource Guide/APTA*.
- Banja, J.D., Wolf, S.L. (1987). Malpractice litigation for uninformed consent. Implications for physical therapists. *Physical Therapy*, 67(8), 1226-1229.
- Fellechner, B.L. & Findley, T.W. (1991). Malpractice in physical medicine and rehabilitation: A review and analysis of existing data. *American Journal of Physical Medicine and Rehabilitation*, 70(3), 124-128.
- Harker, R.C. (1990). Malpractice and other bases of potential liability for the physical therapist. *Risk Management Resource Guide/APTA*.
- Horting, M. (1989). Understanding professional liability. *Clinical Management*, 9(6), 40-46.
- Horting, M. (1990). Understanding your professional liability insurance plan. *Risk Management Resource Guide/APTA*.
- Scanlon, J. (1987). Malpractice. *Today's Student P.T.* Spring, 15-19.
- Scott, R.W. (1990). Informed consent. *Health Care Malpractice: A Primer on Legal Issues for Health Professionals*. SLACK, Inc., Thorofare, N.J.

SHORT TERM COURSES

INSTRUCTIONS FOR SHORT-TERM COURSE ADVERTISEMENTS

Advertisers are requested to include all necessary information for prospective course participants. The Orthopaedic Physical Therapy Practice is published 4 times per year—January, May, August, and November. Ad deadlines are the first day of the preceding month. Rates are \$5.00 per line. Lines may be estimated on a 45 character per line basis (this includes letters, punctuation marks and spaces). The right to reject an ad or change wording is retained by the editor. Ads must be accompanied by payment. Send copy to: Orthopaedic Physical Therapy Practice, 505 King Street, Suite 103, La Crosse, WI 54601.

SURFACE EMG AND BIOFEEDBACK CERTIFICATION IN PHYSICAL AND OCCUPATIONAL THERAPY.

Intensive 5-day course taught by Will Taylor M.D. December 13—17, 1992 in Oakland, California. Includes basic principles, instrumentation training and clinical applications. \$995.00. For more information contact The Stens Corporation at 1-800-257-8367.

REFERENCE LIST NOW AVAILABLE

A reference list published by the Orthopaedic Section, APTA, Inc., is now available for those therapists studying for the specialist certification examination. The reference list was compiled from published references submitted by those who successfully completed the Orthopaedic Clinical Specialist Certification as of January 1992. This list should be useful during preparation, but is not intended to satisfy examination criteria for the Orthopaedic Physical Therapy Specialty Competency exam.

To order, please call the Section office at 1-800-444-3982.

The reference list is free of charge to Orthopaedic Section members. A \$5.00 fee will be charged to non-Section members.

CSM 1993 PROGRAM

Tuesday, February 2, 1993

8:00 AM-5:00 PM
Orthopaedic Section Industrial SIG Pre-conference on ADA
Joint program with Private Practice

Wednesday, February 3, 1993

8:00 AM-5:00 PM
Orthopaedic Section Industrial SIG Pre-conference on ADA continued

Thursday, February 4, 1993

8:00 AM-Noon
Practice Model-Joint Program

8:00-10:00 AM
Head and Neck Round Table

10:00 AM-Noon
Performing Arts Physical Therapy Round Table

Sean Gallagher, P.T.
Shaw Bronner, P.T.
Brent Anderson, P.T.

1:00-3:00 PM
Manual Therapy Round Table
Joe Farrell, M.S., P.T.
"Adverse Neural Tissue Tension: A Case Study"

Michael Moore, P.T.
"Therapeutic Exercise for the Low Back Patient: An Innovative Approach"

12:00-4:30 PM
Outcome Measurements-Joint Program

3:00-4:30 PM
Balance and Proprioception in the Treatment of Chronic Ankle Sprain
Nancy Byl, P.T., Ph.D.
CPT Howard Rice

Friday, February 5, 1993

8:00 AM-5:00 PM
Articular Cartilage-Joint program with Sports and Geriatrics

8:00 AM-5:00 PM
Orthopaedic Section Executive Committee Meeting

3:30-5:30 PM
Concurrent Research Presentations

Saturday, February 6, 1993

8:00-10:00 AM
Orthopaedic Section business meeting

11:00 AM-12:30 PM
Industrial SIG business meeting

Noon-1:00 PM
Performing Arts business meeting

1:00-2:00 PM
Manual Therapy business meeting

1:00-2:30 PM
Concurrent Research Presentations

3:30-4:30 PM
Head and Neck business meeting

3:30-5:00 PM
"PTA Controversial Practice Issues"
Joint program with Licensure and PPS
Carol Schunk, P.T.
Cheryl Carpenter, P.T.A.
Bonnie Blossom, P.T.
Phil Tygiel, P.T.

3:30-5:30 PM
Concurrent Research Presentations

7:00-10:00 PM
Black Tie and Roses

Sunday, February 7, 1993

8:00 AM-Noon
Standardization of Testing for Postural Dysfunction
Florence Kendall, P.T.
Patricia G. Provance, P.T.

1992 MASTER CALENDAR

July						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

August						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

September						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

October						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

November						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

December						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

NOVEMBER

- 1 Mary McMillan Scholarship Award Deadline
- 5 OP Mailing Date
- 11 Veterans Day
- 11-15 Review for Advanced Orthopaedic Competencies - Detroit, MI
- 18 JOSPT Mailing Date
- 26 HOLIDAY - Thanksgiving Day

DECEMBER

- 1 Nominations for Paris Distinguished Service Award due to the Section office
- 1 Nominations for all APTA Special Awards due to the National office
- 18 JOSPT Mailing Date
- 25 HOLIDAY - Christmas Day

JANUARY

- 1 HOLIDAY - New Years Day
- 4 OP Mailing Date
- 18 JOSPT Mailing Date



Because Your Hands Are Your Scalpel.

In manual therapy, our fingers and hands are the tools we use to explore, diagnose and treat. This new series of videos, featuring renowned Dutch physiotherapist Dos Winkel and the faculty of the International Academy of Orthopedic Medicine, demonstrates *unique and practical* techniques using anatomical mapping and joint pathology for manual therapy and conservative orthopedics.

The **Orthopedic Medicine & Manual Therapy Series** consists of six comprehensive videotape sets, each focusing intensive study of *three to four hours* devoted to *each* joint structure. Each tape set includes four 45-60 minute tapes; two each for manual therapy and orthopedic medicine. Through these programs, you will gain the ability to perform effective, local treatment through accurate surface mapping of

functional anatomy, differential diagnosis using joint pathology, and treatment combining soft tissue and specific articulation techniques.

Dos Winkel's approach to orthopedic medicine evolved from the works of Cyriax, under whom he studied, and other noted manual therapy experts.

The video programs include: 1) The Knee; 2) The Shoulder; 3) The Hip; 4) The Wrist and Hand; 5) The Ankle and Foot; and 6) The Elbow. Available exclusively in North America only through OPTP. Call toll-free in the U.S. or Canada **1-800-367-7393** or write for complete information.

OPTP

A DIVISION OF POSITEX, INC.

P.O. BOX 47009, MINNEAPOLIS, MN 55447-0009 • TOLL-FREE: 1-800-367-7393

FINANCIAL REPORT

Orthopaedic Section, APTA, Inc. 9/7/92

INCOME:

Our Section is doing very well this year. We are 18.7% over our expected revenues YTD. This is mainly due to the success of our continuing education courses. Member dues are slightly behind expectations but are expected to be around budget by December 31, 1992.

EXPENSES:

YTD we are 19.7% under our budgeted expectations. Travel expenses are down due to reduced air fares and general operations doing a good job of watching the budget.

INVESTMENTS/RESERVES:

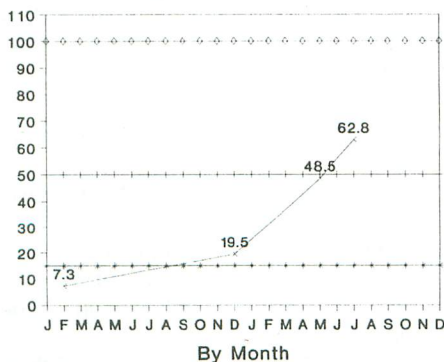
Our reserves continue to build. Our reserve fund is currently .62% of our annual expense budget. The Finance Committee is recommending to the Executive Committee that the fund should grow to .75%. At that time the new building fund would be started.

FINANCE COMMITTEE

The Finance Committee met in La Crosse Aug. 28-30th. The entire fiscal operations were reviewed and the 1993 budget prepared for the Fall Executive Committee Meeting. Attending the meeting were:

Annette Iglarsh	President
Terri Pericak	Admin. Director
John Wadsworth	Treasurer
Dorothy Santi	Member
Don Lloyd	Member
Dottie Nelson	Member

RESERVE FUND 1991 AND 1992



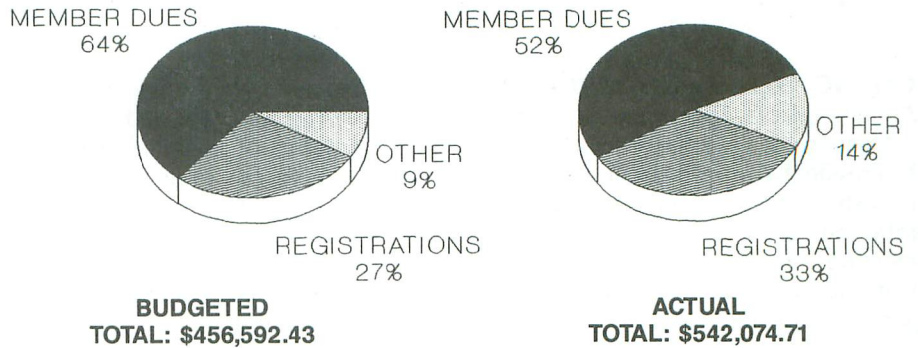
1993 Goal Minimum
Reserves 1995 Goal

Goal: Reserve = 75% of Annual OP Budget

ORTHOPAEDIC SECTION APTA INC.

1992 INCOME YTD 7/31/92

BUDGET TO ACTUAL BY %

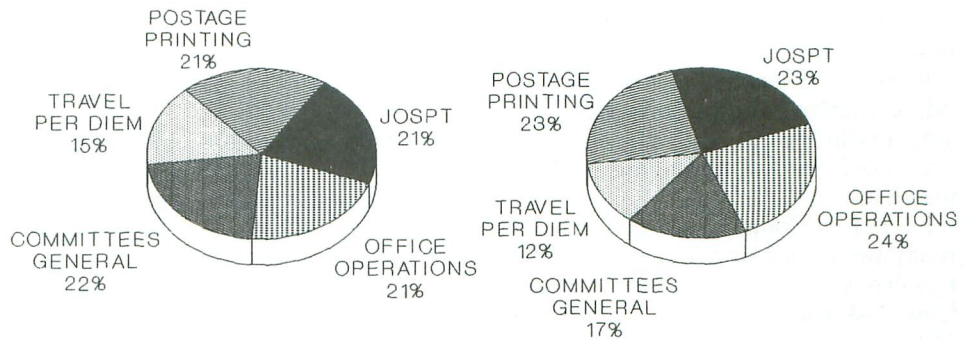


**BUDGETED
TOTAL: \$456,592.43**

**ACTUAL
TOTAL: \$542,074.71**

1992 EXPENSES YTD 7/31/92

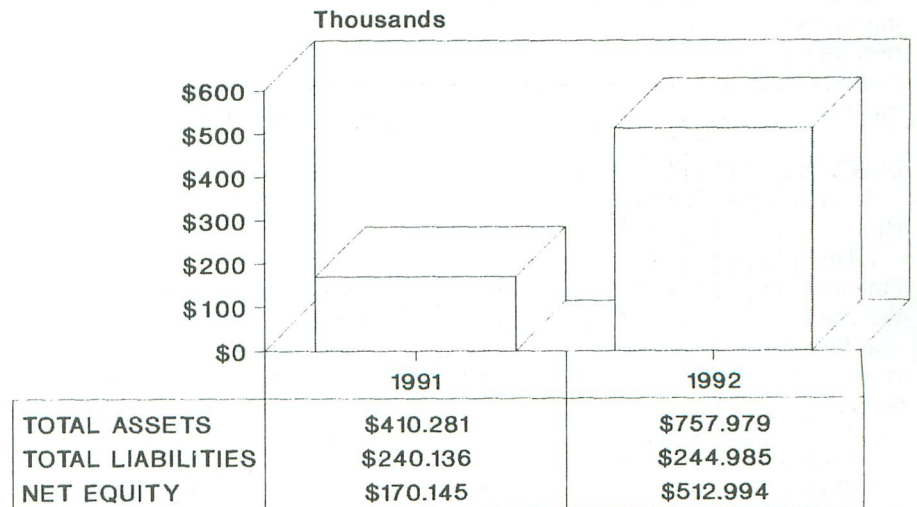
BUDGETED TO ACTUAL BY %



**BUDGETED
TOTAL: \$402,371.75**

**ACTUAL
TOTAL: \$322,968.33**

BALANCE SHEET (SUMMARY) 7/31/92



NET EQUITY

MEETING MINUTES

BUSINESS MEETING,
JULY 24, 1992
REVIEW FOR ADVANCED
ORTHOPAEDIC COMPETENCIES
BALTIMORE, MARYLAND
MINUTES

CALL TO ORDER AND WELCOME—

Annette Iglarsh, P.T., Ph.D.

Meeting was called to order at 1:45 PM by President, Annette Iglarsh. The following exhibitors were thanked for their contribution in sponsoring the business meeting luncheon; Foot Management, WB Saunders, Ariel Life Systems, Williams and Wilkins, and STE.

PRESIDENT'S REPORT

Current Activities of the President and Executive Committee

A. Review current policies and procedures of the Section.

B. Review Executive Committee and Administration reorganization to be consistent with the APTA structure.

C. Look into reorganizing Section workload.

D. Look at Committee structure. Currently we are looking into dividing the Practice Affairs Committee into a Legislative Task Force and a Reimbursement Task Force. The Reimbursement Task Force will look into a computerized information network which will record worker's compensation information from state to state. The Legislative Task Force will stay informed as to what is happening in each state and on Capital Hill to provide members with appropriate information to help them deal with encroachment issues locally.

EXECUTIVE COMMITTEE REPORTS

A. Treasurer—John Wadsworth, M.A., P.T.

1. The Treasurer is also the Chair of the Finance Committee whose responsibilities are to:

- Develop the annual Section budget, implement that budget and track that budget.
- Review and set fiscal policies.
- Review Section investment.
- Review various contracts that the Orthopaedic Section has.
- Oversee the JOSPT and its operations.
- To develop financial security for the Section.

2. The 1992 Section budget:

a. Income for the Section is 17% above what was projected year-to-date. The educational programs are the main reason for this. The better these educational programs do the more we can hold down dues increases.

b. Expenses for the Section are 20% under what was expected year-to-date.

c. In terms of financial stability, our original goal was to get a reserve fund up to 25-30%. Currently the Section is at 28%. Our long range goal is to have the reserve fund at 50%.

3. Breakdown of \$50 dues payment per member per year

- 30% goes to producing *JOSPT*
- 20% goes into the Section reserve fund
- 24% goes toward business office operations
- 26% goes toward committee operations

B. Member-at-Large—Stanley Paris, P.T., Ph.D.

1. One of the main responsibilities of the Member-at-Large is to keep the Section Bylaws up to date.

2. The Member-at-Large is also the Executive Committee liaison to the Practice Affairs and Nominating Committees.

3. Addressing poor attendance at Orthopaedic Section business meetings is a main concern.

4. The American Academy of Orthopaedic Manual Physical Therapy (AAOMPT) is working closely with the Orthopaedic Section towards the development of practical examination standards in addition to written standards in the area of manual therapy.

5. Defense of practice is also a major issue which the Section is now beginning to address.

C. Research Committee Chair—Dan Riddle, M.S., P.T.

1. Main role as member of the Executive Committee is to serve as a spokesperson and an advocate for research in orthopaedics and provide the Executive Committee with input on research needs and funding in orthopaedics.

2. The Research Committee has two primary activities:

- Coordinate the call for papers and presentations at CSM.
- Serve as the decision making body

for the Rose Excellence in Research Award.

c. The Chair serves as the liaison between the membership and experts in the field of research.

D. Education Program Chair—Nancy White, M.S., P.T.

1. The Section is offering a second review course this year in November in Detroit due to a special request from that area.

2. Due to the large response to the review course this year, the Section will be offering two per year beginning in 1993. They will be in July and November. We will continue to offer two a year as long as there is a demand.

3. Home Study Courses

a. The third home study course is presently being planned. The topic is the upper extremity and it will be offered early in 1993.

b. The first home study course on the lower extremity will be re-run sometime in 1993.

4. 1993 Combined Sections Meeting in San Antonio

a. Extensive programming will be provided for the round tables and special interest group; Performing Arts Physical Therapy, Manual Therapy, Head and Neck, Foot and Ankle and Industrial Physical Therapy.

b. We are also looking for anyone who would like to get more involved in the foot and ankle area by putting together some round tables at CSM and Annual Conference. Please get in touch with us if you are interested.

c. A two day pre-instructional course on the ADA will be held right before CSM. This is being put on by the Industrial Physical Therapy Special Interest Group.

E. Administrative Director—Terri Pericak

1. Orthopaedic Section staff responsibilities

a. Nancy Yeske is in charge of all membership services and organizes the 'Review for Advanced Orthopaedic Competencies' courses.

b. Sharon Klinski is the Section Publications Coordinator. Sharon is Managing Editor of *Orthopaedic Physical Therapy Practice* for the Orthopaedic Section, which is published quarterly; She pub-

lishes *Geritopics*, quarterly, for the Geriatric Section, and; she just began publishing the Hand Section publication this year. In addition, we hope to start publishing the Cardiopulmonary Section publication in 1993.

Sharon also administers the home study courses. The editor of these courses is Kent Timm, P.T., Ph.D.

Sharon is the contact person at the Section office for all of the round table and special interest group activities.

c. The main responsibilities of the Administrative Director are to oversee all activities at the Section office, prepare the annual strategic plan and budget, monitor the day to day finances, and work closely with all the Committee Chairs and Executive Committee officers.

2. Orthopaedic Study Groups

The Section is working on organizing study groups. A survey was sent out to all study groups to obtain more information on their activities and what involvement, if any, they would like to see the Orthopaedic Section have. One of our members, Mike Tollan, P.T., OCS, in Tacoma, WA, is heading up this project.

3. The Orthopaedic Section is the largest Section of APTA with 10,700 members. We are always looking for new people to serve on committees and become involved in the Section. If you are interested, please contact any of us at the Section office.

F. Immediate Past President—Jan K. Richardson, P.T., Ph.D., OCS

1. Orthopaedic Specialization Process

During the past year all the Orthopaedic Certified Specialists were queried as to what reference books they felt were most beneficial to them in studying for the exam. The references were compiled and organized by subject area by the Research Committee Chair. The Section office will publish this listing in the Fall of 1992. The reference list will be available through the Section office.

2. AAOMPT

The Academy has been in existence for 18 months. They notified the Orthopaedic Section and the APTA that they wished to maintain open dialog and a good working relationship in their pursuit to have a document submitted to IFOMT for recognition of the U.S. as a full voting member to IFOMT. The U.S. has been a dues paying member of IFOMT but non-voting, since its inception. Without the examination process in place, which included a residency and practical exam, the U.S. was not recognized as a full voting member. At the IFOMT meeting in June of 1992 in Vail, CO, the U.S. was

recognized as a full voting member contingent on the Academy have written documentation by the APTA that they would be recognized as the USA representative for orthopaedic manual physical therapy. Joe Farrell, Chair of the Academy, will present to the APTA Board of Directors in November. The Academy is using *Orthopaedic Physical Therapy Practice* to continue to communicate to Orthopaedic Section members as to the activities that are transpiring.

PROGRAM REPORTS

A. Public Relations Committee—Annette Iglarsh, P.T., Ph.D.

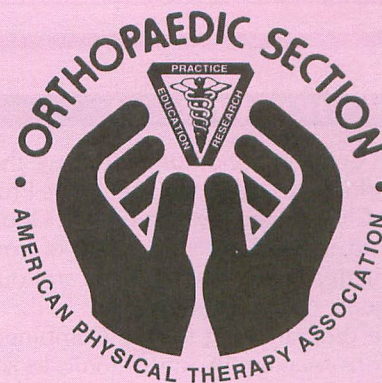
Jonathan Cooperman, M.S., P.T., was appointed Publications Committee Chair at Annual Conference in June and as a result will be vacating the Public Relations Chair position. At this meeting the Section Executive Committee appointed Karen Piegorsch, P.T., OCS, as the new Chair to this Committee. Karen has served as a member on this Committee for several years and will be looking for new committee members. Please let us know if you are interested.

B. Nominating Committee—Annette Iglarsh, P.T., Ph.D.

1. There will be two vacancies in the upcoming 1993 Section elections. They are Treasurer and Nominating Committee Member. Nominations for these positions are accepted up until the close of the Section business meeting at CSM in San Antonio, February 6, 1993. There is one restriction, to be elected Treasurer you must have served on the Finance Committee.

2. There will be vacancies in National APTA office positions in 1993. Since the Section does not currently have a vote in the House of Delegates, the only way we can have a voice in the House is to serve as delegates and run for National office. The Section is committed to support our members who seek National office and we also like to support our members who deserve and seek recognition in the areas of several awards that are given. The deadline for submitting nominees for National office and awards is generally November 1. Please contact us if you would like to nominate yourself or someone else.

Adjournment



Orthopaedic Section Administrative Staff

Terri A. Pericak, Administrative Director
Sharon L. Klinski, Publications/Special
Projects Coordinator
Nancy B. Yeske, Management System
Coordinator

Contact Terri Pericak for:

- Finance/Administration
- Section Executive Committee
- Meeting Services
- Nominations
- Mentorship/Study Group Activities

Contact Sharon Klinski for:

- *Orthopaedic Physical Therapy Practice*
- Publication Content
- Industrial Physical Therapy Special Interest Group
- Home Study Courses
- Contract proposals for Administrative Services
- Contract proposals for newsletters & journals

Contact Nancy Yeske for:

- Membership Services
- Address changes
- Orthopaedic Section membership labels
- Promotional Items
- Review for Advanced Orthopaedic Competencies Course

OFFICE HOURS

8:00 AM - 4:30 PM CST

Please leave a message on the answering machine if you cannot call during these hours. We will gladly return the call!

SECTION NEWS

EDUCATION PROGRAM

It is quite an honor for me to have the opportunity to serve the Section as Program Chair for the next three years. I look forward to working with many of you during this time as we work to carry out the goals of the Section.

The programming for the Combined Sections Meeting in San Antonio looks fantastic! We will kick off with a two day pre-conference course on the ADA which is being coordinated with the Section's Industrial Special Interest Group and the Private Practice Section. CSM itself is packed with roundtable discussions on specialized topics, joint programming with other sections, a record number of platform presentations, and special Orthopaedic Section programming. As a grand finale on Sunday, Florence Kendall and Patricia

Provance will speak for a half day on Standardization of Physical Therapy Testing for Spinal Dysfunction. A highlight of CSM is always the Black Tie and Roses Reception and Awards Ceremony. This year will be no exception as the event takes on a Texas flare. Make plans to attend!

Our Home Study Courses continue to be quite successful. We have just completed our second series and will soon begin the third course on the upper extremity. Kent Timm continues to do an excellent job as Editor of these series. Look for information on the upper extremity course in this issue.

The July "Review for Advanced Orthopaedic Competencies" was our most successful to date with 140 registrants. The seven day course featured six excellent speakers and four special topic workshops in the afternoons following the

sessions. The Section officers were present on one day for a luncheon business meeting with all the attendees. This turned out to be a good way for us to interact with Section members on a local level.

At the time of this printing, registration is going well for the five day November Review Course in Detroit. We are pleased to offer this second course this year in the Midwest as a convenience to Section members in this part of the country.

I welcome input on Section programming from all Section members at any time. Please let me know how we can best meet your needs.

Nancy T. White, M.S., P.T.
Chair, Education Program Committee

Request for Recommendations for Orthopaedic Section Offices

The Orthopaedic Section of the APTA needs your input for qualified candidates to run for the offices listed below. To serve is exciting and an honor! If you would like the opportunity to serve the Section or know of qualified members who would serve, please fill in the requested information. Return this completed form to the Chair of the Nominating Committee as soon as possible before January 1, 1993. The Nominating Committee will solicit the consent to run and biographical information from the person you recommend.

CHECK THE APPROPRIATE POSITION:

- TREASURER (3 years):
Should have good working knowledge of accrual accounting, annual and long range budgeting, reserve funds and investment strategies.
- Nominating Committee Member (3 years):
Should have broad exposure to membership to assist in formation of the slate of officers.

PLEASE RETURN BY JANUARY 1, 1993 TO:

William Boissonnault, M.S., P.T.
Orthopaedic Section, APTA
505 King Street, Suite 103
La Crosse, WI 54601

Nominator: _____

Address: _____

Phone: _____

(print full name of recommended nominee)

Address City State Zip

(Area code) Home Phone Number

(Area code) Office Phone Number

is recommended as a nominee for election to the position of:

Neck Care Program

Newly Revised for 1992

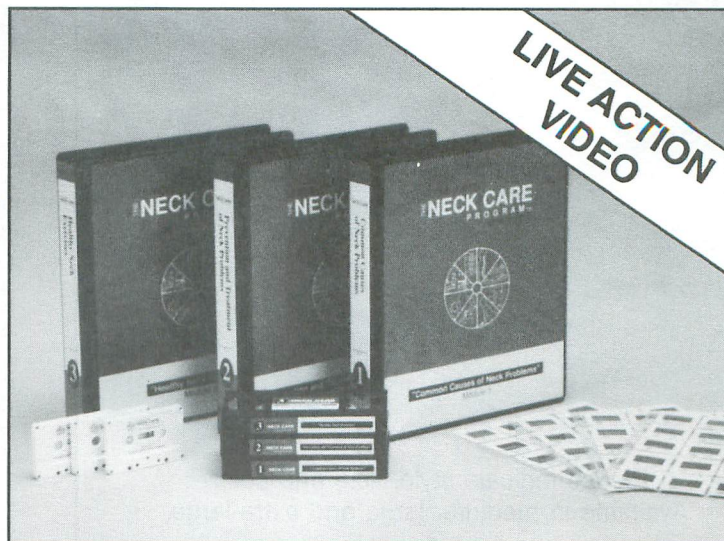
Second Edition

THE NECKCARE PROGRAM™

by H. Duane Saunders, M.S., P.T.
and Mark A. Anderson, M.A., P.T.

The Neck Care Program is a Slide / Tape Video Program for teaching patients/workers Neck Care and Neck Injury Prevention.

The Neck Care Program is divided into three teaching modules. Each module is designed to stand alone and can be purchased separately. The complete package includes high quality slides including many examples of men and women in actual living and working situations. It also includes cassettes and video tapes. Complete written instructions, suggestions and promotional materials are included.



The Neck Care Program compliments the Back Care Program Fourth Edition 1992

Each module is 12 to 15 minutes in length and can be purchased separately.

Available on a **10 DAY TRIAL** -No obligation.

ORDERING INFORMATION

Order Individual Modules in either Slide/Tape or Video or Both.
ORDER BY MODULE NUMBER OR COMPLETE SET.

CODE	DESCRIPTION	PRICE
0300-Module#	Individual Video Modules	\$195.00 EA
0310-Module#	Individual Slide/Tape Modules	225.00 EA
0320-Module#	Individual Slide/Tape and Video Modules	275.00 EA
03000	Complete Set Videos (3 Modules)	395.00 EA
03100	Complete Set Slide/Tape (3 Modules)	495.00 EA
03200	Complete Set Slide/Tape and Videos (3 Modules)	695.00 EA
03299	Preview	No Charge

Plus shipping and handling

MODULE 1
Common Causes
of Neck Problems

MODULE 2
Prevention and Treatment
of Neck Problems

MODULE 3
Healthy Neck
Exercises

**THIS PROGRAM
HAS BEEN
COMPLETELY REVISED.
THE VIDEOS ARE
LIVE ACTION**

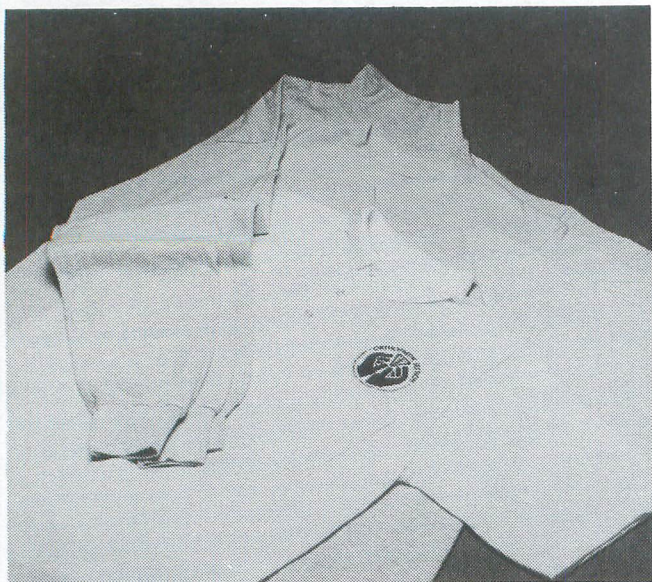


To Order Call or Write:
Educational Opportunities
A Saunders Group Company

7750 West 78th Street, Minneapolis, MN 55439

Direct Order Line: 1-800-456-1289
General Information: 1-800-654-8357
1-612-944-1656 Fax: 1-612-944-1340

ORTHOPAEDIC SECTION LOGO T-SHIRTS



Please indicate style, size and color.
Available in medium, large and extra-large.

_____ **Fruit of the Loom Sweatshirts** (grey with blue imprint, white with blue imprint) cotton/polyester (**\$20 Section Members, \$25 non-Section Members**)

_____ **Mock Turtle-Neck/Long Sleeves** (white with blue imprint, grey with blue imprint, black with gold imprint) 100% cotton, preshrunk (**\$16 Section Members, \$21 non-Section Members**)

_____ **Golf Shirts with Pockets and Fashion Collar** (white with blue imprint, light blue with blue imprint) cotton/polyester (**\$18 Section Members, \$23 non-Section members**)

_____ **Total Amount Enclosed**

Name _____
(PLEASE INCLUDE ORTHOPAEDIC SECTION MEMBER'S NAME)

Address _____

City _____ State _____ Zip _____

Telephone _____

**Please add \$2.50 per order for postage and handling.
Wisconsin residents add 5½% sales tax.**

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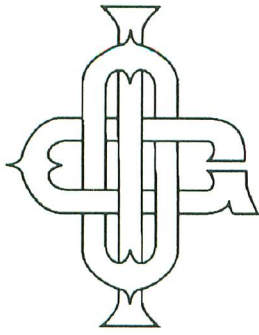
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The Ola Grimsby Institute, Inc. is beginning Part Time Residency Programs in Manual Therapy starting in January 1993 in the following locations:

Albuquerque, NM	Nashville, TN
Dallas, TX	Little Rock, AR
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Please contact the Institute at (619) 483-7246 for applications and information.

The Ola Grimsby/Sorlandets Institute Course Calendar 1992-1993

EXTREMITY	OCT 28-NOV 1	DETROIT, MI	DAN VAUGHN (313) 475-8385
EXTREMITY	JAN 27-31	PHOENIX, AZ	KEITH KOCHER (602) 649-1750
THE SPINE	FEB 10-14	DENVER, CO	ROGER RETTIG (303) 460-9129
THE SPINE	FEB 24-28	SEATTLE, WA	BRAD JORDAN (206) 259-0239
EXTREMITY	MAR 3-7	LOS ANGELES, CA	DAVID PEVSNER (818) 996-1210
MET	MAR 13-16	CHICAGO, IL	BECKY SCHULTZ (815) 344-1919
MET	MAR 20-23	LONG ISLAND, NY	HOWARD MAKOFSKY (516) 968-3400
EXTREMITY	APR 28-MAY 2	SAN DIEGO, CA	LAURA RODGERS (619) 943-1849
EXTREMITY	MAY 12-16	NASHVILLE, TN	DAVID SHEER (615) 320-7302
THE SPINE	MAY 15-19	LITTLE ROCK, AR	ROB TILLMAN (501) 228-6303
MET	JUNE 3-6	NEW ORLEANS, LA	JAN CABE (619) 483-7246
MET	JUNE 10-13	NORFOLK, VA	CHRIS MASSONEAU (703) 942-6282
THE SPINE	JULY 28-AUG 1	MINNEAPOLIS, MN	JOE DIGIOVANNI (612) 473-4972
THE SPINE	AUG 4-8	CHARLESTON, WV	MIKE KESSLER (304) 253-7205
MET	SEPT 9-12	CLEVELAND, OH	JEFF CLOLEK (216) 238-9554
THE SPINE	SEPT 11-15	DETROIT, MI	PAM VAUGHN (313) 475-3923

**The Ola Grimsby Institute, Inc.
1742 Garnet Avenue - Suite 386
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